Section III – Appendix

Home Delivered Meal Program Evaluation

SUFFOLK COUNTY OFFICE FOR THE AGING
EVALUATION
HOME DELIVERED MEAL PROGRAM

DATE:_____

TE:_____ MANAGER:_____

ACTUAL HOME DELIVERED MEALS:_____

MENU: _____ _____ _____

1. MEAL PACKAGING, TEMPERATURE AND EQUIPMENT

	Yes	No
1. Are cold foods kept refrigerated until packed into carriers with ice?	___	___
2. Are all meal components served?	___	___
3. Are hot and cold foods packed in separate carriers?	___	___
4. Are food carriers clean and sanitary?	___	___
5. Are hot foods kept hot until packed in carriers?	___	___
6. Is there a method to distinguish therapeutic meals or clients requesting therapeutic meals?	___	___
7. Are hot foods served at 140 degrees F and above?	___	___
Are cold foods served at 41 degrees F and below?	___	___
9. Are temperature records reviewed by the RD or someone working under the direction of the RD?	___	___
10. Have staff/volunteers been instructed on service procedure ahead of time?	___	___
11. Have drivers been given written delivery instructions?	___	___

12. Time & food temperatures at first reading: Time:_____ Temps: Protein _____ Starch_____
Vegetable _____

13. Time & food temperatures at last house: Time:_____ Temps: Protein _____ Starch_____
Vegetable _____

14. How often does the driver take the temperature of the final meal delievered?
Daily_____ Weekly_____ Other_____

II. METHOD OF CONTRIBUTION COLLECTION

14. How are contributions collected? Daily_____Weekly_____Monthly_____

III MILEAGE OF VEHICLE

What is the mileage of the vehicle?_____ VIN # of Vehicle (last four digits) _____

16. Is the funding stream of the vehicle in place?
Comments:

Programmatic Monitoring

PROGRAMMATIC MONITORING REPORT

Program/Service Provider Name/Address _____

_____

_____

_____

Amount of Contract:_____

Contract Period:_____

Services:

_____

_____

_____

Date of Site Visit: _____/_____/_____

Area Agency on Aging Monitor:

_____

Program Director: _____

Others Participating in Monitoring:

_____

Name/Title/Agency/Phone No.

_____

Name/Title/Agency/Phone No.

_____

Name/Title/Agency/Phone No.

I. PAST PERFORMANCE/PREVIOUS RECOMMENDATIONS

1. Review Findings

Was your last monitoring in compliance? Yes _____ No _____

Review findings from prior or current year monitoring and corrective actions taken to address areas of non-compliance. Were all findings from the Area Agency on Aging (AAA's) previous monitoring efforts satisfactorily addressed?

Yes _____ No _____ N/A _____

If no, please describe: _____

_____

_____

_____

II. SERVICE ACTIVITY REVIEW

1. Units of Service

Name of Service	Projected Units	YTD Units	Percent of Projection	Percent of Year Elapsed
Congregate				
Home Delivered				

1a. Describe reason(s) for any variances: _____

_____

_____

_____

2. Expenditures

(Review expenditures with Suffolk County Office for the Aging (SCOFA) fiscal staff. Complete this section prior to on-site monitoring. Discuss the findings with the contractor.)

Name of Service	Projected Expenditures	YTD Expenditures	Percent of Projection	Percent of Year Elapsed
Congregate				
Home Delivered				

2a. Describe reason(s) for any variance:

_____

_____

3. Verification of Reported Units and Clients

(The person monitoring the service program will randomly select a report submitted by the program to SCOFA and will verify the documentation supporting the reported units of service and reported clients.)

Report Reviewed_____

3a. ***Units of Service***

Name of Service	Number of Units Reported to SCOFA	Documented Units
Congregate		
Home Delivered		

Note any discrepancies and apparent reasons: _____

_____

_____

_____

Note supporting documentation reviewed: _____

_____

_____

_____

_____

3b. ***Clients Served*** *(Unduplicated Count)*

Name of Service	Number of Cases Reported to SCOFA	Documented Clients
Congregate		
Home Delivered		

Note any discrepancies and apparent reasons: _____

_____

_____

_____

Note supporting documentation reviewed: _____

_____

_____

_____

_____

3c. ***Outreach Units*** N/A _____

Outreach	Number of Units Reported to SCOFA	Documented Units

Note any discrepancies and apparent reasons: _____

_____

_____

Note supporting documentation reviewed: _____

_____

_____

3d. ***Transportation Units*** N/A _____

Name of Service	Number of Units Reported to SCOFA	Documented Units
Regular Transportation		
AAA Transportation		

Notes: _____

_____

_____

Is there a contribution required for transportation? Yes _____ No _____ N/A _____

How is client informed? **Attach copy**

_____

_____

_____

If so, what is the amount of the contribution? _____

Note any discrepancies and apparent reasons: _____

_____

_____

Note supporting documentation reviewed: _____

_____

_____

_____

3e. ***Electronic Reporting*** ***Month*** _____ ***Year*** _____

Name of Service	Electronic Numbers of Units Reported	Documented Units
Unduplicated Count - Cong.		
Unduplicated Count - HDM		
Shelf Stable Meals - Cong		
Shelf Stable Meals - HDM		
Transportation - Reg.		
Transportation - AAA		
Units Served - Cong		
Units Served - HDM		
Eligible Guests		
Ineligible Guests		
Outreach		

Notes: _____

_____

_____

Is data being input in a timely fashion? (12th of the month)

Yes _____ No _____

If no, please describe reasons for lateness and any actions being taken by the program/service provider to improve the timeliness of reporting: _____

_____

_____

4. Timeliness of Reporting

Due Date for Reports in this Contract/Project Period	Actual Dates When Reports Were Received by SCOFA

4a. Are reports received in a timely fashion?

Yes _____ No _____

If no, please describe reasons for lateness and any actions being taken by the program/ service provider to improve the timeliness of reporting:_____

_____

_____

III. TARGETING COMPLIANCE

(Complete the charts prior to on-site monitoring visits utilizing targeting data for their service area. Refer to proposal that was submitted to SCOFA prior to signing contract and 2010 census data. Discuss the findings with the contractor).

1. Minority Elderly Served

Describe the outreach activities utilized by the program service provider to satisfy the needs of minority elderly served:

- Use census data (as reviewed with SCOFA) to identify target neighborhoods.

- Translated program brochures and pamphlets into appropriate languages (use LEP device when necessary).

- Prominent location of senior sites to maximize potential such as within senior complex.

- Conduct door-to-door or group presentations in senior housing facilities.

- Locate information racks at churches and community centers clubs, senior housing etc.

- Arrange for speaking engagements to organizations that include minorities.

- Publicize services through press releases, radio, television, local publication and newsletters.

- Use minority staff and interns on local programs or in conducting outreach.

Targeting Activities Stated in Proposal: _____

_____

Other Activities Conducted: _____

_____

_____

_____

Name of Service	Percentage of Minority Elderly In Elderly Population in Catchment Area	Total Clients Served YTD	Total Minority Clients Served YTD	Percentage of Minority Elderly Among Total Client Served YTD

1a. Is the program/service provider meeting its goals of providing services to minority elders at least in proportion to their representation in the total elderly population within the service provider's catchment area?

Yes _____ No _____

If no, please describe reasons for any variances as well as any actions being taken by the program/service provider to increase participation by minority elderly:

_____

_____

2. Access to Telephonic Interpretation Services

1. Has the program/service provider set up a contract with a telephonic interpretation provider?

Yes _____ Name of Contractor _____ No_____

If no, please explain the steps that are being taken to comply with this service:

_____

_____

2. Is the program/service provider staff trained to access this service?

Yes ____ No _____

If no, please explain the training plan:

_____

_____

Name of staff who demonstrated the ability to access this service_____

_____

_____

Describe how staff accessed this service: _____

_____

_____

3. Is there a written notice in languages that Limited English Proficiency (LEP) persons will understand at service locations?

Yes _____ No _____

Please describe:

_____

_____

_____

IV. COORDINATION

1. Has the program/service provider worked effectively with other providers and organizations to facilitate coordination and minimize possible duplication of effort?

Yes _____ No _____

1a. Activities undertaken by the program/service provider to facilitate coordination include:

- Participating in inter-agency meetings to plan and coordinate services

- coordination of funding proposals with other human services organizations

- Memorandum of Understanding (MoU) or agreements with other organizations (for example agreements on coordination of transportation routes, recreational activities or meal production)

- working with other providers to update service directories or listings of available services

- coordination of referrals and follow-ups with other local service providers

Other activities:_____
_____

Documentation reviewed (agendas or notes from inter-agency meetings, protocols for referrals, copies of MoUs or agreements with other organizations, documentation of efforts to develop a central assessment unit or update services listings).

V. STAFFING

1. Does the program have adequate staff to perform the activities required under its contract/agreement with SCOFA?

   Yes _____ No _____

   If no, please explain the impact on the program and any steps being taken to improve staffing levels:_____
   _____
   _____

2. Are qualified case managers or assessors employed to complete necessary assessments (Congregate-NAPIS Short Form; HDM-COMPASS long form)?

   Yes_____ No _____ N/A _____

   Documentation reviewed (staff resumes, documentation of certification, food manager certificate or degree): _____
   _____
   _____
   _____

3. Does the program have a training plan for service staff designed to assist staff in carrying out assigned tasks such as Food Manager's Course, Licensed Drivers, Seminars, SAMS Training, LEP (Limited English Proficiency) Training, HDM Assessment Education Level and Training?

   Yes _____ No _____

Documentation reviewed (training plans, training agendas): _____

_____

_____

_____

4. Does a random check of the service provider's files verify the type of training actually provided for staff, the date, the presenter and his/her qualifications, and the material covered?

Yes _____ No _____

If yes, please note the documentation that was reviewed: _____

_____

_____

_____

5. Compliance with Affirmative Action and Equal Employment Opportunity (EEO) guidelines

5a. Do staffing patterns reflect the minority representation in the total population?

Yes _____ No _____

Comments:_____

_____

5b. Is an EEO sign posted in a prominent location?

Yes _____ No _____

Please describe:_____

_____

_____

5c. Are reasonable accommodations made for staff and volunteers with disabilities?

Yes _____ No _____

Please describe accommodations observed or documented: _____

_____

_____

_____

VI. ADMINISTRATION/MANAGEMENT

1. Is this program open to the public?

   Yes_____ No _____

   Comments:_____
   _____

   Documentation reviewed (statements on program materials that activities are open to the general public, on-site observation of the activities):_____
   _____
   _____

2. Are the facilities where client activities and services take place free from political posters and other evidence of advancing ones political candidate over another?

   Yes _____ No _____

   Comments:_____
   _____
   _____

3. Are the services/activities carried out under this contract or program secular in nature (that is, provided without evidence of any religious services, counseling or religious instruction)?

   Yes_____ No _____

   Comments:_____
   _____

   Documentation reviewed (signs, posters or program materials announcing that services are available to all eligible individuals regardless of religious affiliation, on-site observation):_____
   _____
   _____

** ***Prior to the on-site monitoring, review the funding logo stated in the contract.***

4. Has the program/service provider given due recognition to SCOFA and the appropriate agency (see individual contracts), as appropriate, in program/service brochures, flyers and other printed materials?

   Yes_____ No _____

   Documentation reviewed ("due credit" statements in program materials copies of news articles citing Federal/State funding through SCOFA/appropriate agency): **Attach copies**

   _____
   _____
   _____

5. Has the program/service provider made provisions for retaining all records pertinent to the program, both program and fiscal, for a period of six years?

   Yes_____ No _____

   Documentation reviewed (written policies and procedures covering maintenance of records):_____
   _____
   _____

6. Has the program/service provider made provisions for treating client information confidentially?

   Yes_____ No _____

6a. Ask to see where client and personnel files are kept. Note if there is a lock on the cabinet. Ascertain how many keys there are and who has them. Ask whose responsibility it is for locking up files at the close of the day._____
   _____
   _____
   _____
   _____
   _____

   Documentation reviewed (written policies covering confidentiality, training agendas noting discussions of confidentiality, on-site observations of staff returning client materials to locked files):_____
   _____
   _____
   _____
   _____

7. Does the program/service provider maintain sufficient documentation for equipment purchased with AAA funds?

Yes_____ No _____ N/A _____

Documentation (purchase orders, invoices, receiving reports, equipment inventory):____

_____

_____

8. Review the contractor's inventory control system. Compare the contractor's inventory sheet(s) with SCOFA's inventory. Spot check 2-3 items on this list. Is the Suffolk County inventory sticker in place?

Yes _____ No _____ N/A _____

Describe:_____

_____

_____

9. Is the equipment purchased with AAA funds identified as such either in property records or fund codes marked on the property?

Yes _____ No _____ N/A _____

10. Is the equipment purchased with AAA funds being used solely to benefit older persons (unless costs are appropriately pro-rated)?

Yes _____ No _____ N/A _____

Documentation (equipment inventories, on-site observation of equipment tags):_____

_____

_____

VII. SAFEGUARDING FUNDS/PROTECTING ASSETS

1. Are staff who handle monies (with the exception of government employees and attorneys) bonded? **Not applicable if there is no budget, just a rate page.

Yes _____ No _____ N/A _____

Documentation (letters concerning bonding of employees, agreements, etc.):_____

_____

_____

2. Are individuals who are authorized to sign checks:

   a. not involved in processing invoices? Yes ____ No ____

   b. different from the person who maintains payroll records?
   Yes ____ No ____

   c. is there a corporate/town policy in place? Yes ____ No ____

   Documentation (written policies & procedures concerning the issuance/signing of checks):_____
   _____
   _____
   _____

VIII. SERVICES/CONTRIBUTIONS/SURVEY LETTERS

(Both Congregate and Home Delivered Services)

1. Are two individuals involved in the counting of client contributions?

   Yes _____ No _____

   Documentation (written policies & procedures concerning the handling of contributions, on-site observations of contributions being counted):_____
   _____
   _____

2. Are the daily contributions received entered into a ledger by check number/amount of money (not client names) and co-signed by the two individuals who counted them?

   Congregate: HDM:
   Yes _____ No _____ Yes _____ No _____

   Describe:_____
   _____
   _____
   _____

3. How often are the contributions deposited in the bank?

Daily ____ Weekly ____ Other ____

If contributions are not deposited daily, in what safe location are they held until they are deposited? Describe:_____

_____

_____

_____

** **Prior to the on-site monitoring, review one month's voucher for contributions received. At the time of the monitoring visit, examine that month's daily contribution log and verify that same amount is reported on the voucher.**

Month of:_____Describe:_____

_____

4. Is a system in place to allow clients to voluntarily and confidentially contribute to the cost of services?

Yes _____ No _____

Documentation (contribution procedures, statements in letters and program brochures concerning policies, on-site observation of contribution collection practices): **Attach copies of written materials**: _____

_____

_____

5. Does the program/service provider have a procedure which allows clients or applicants for services to present grievances on the denial of services or to make complaints about the provision methods/quality of services?

Yes _____ No _____

Documentation reviewed (client satisfaction survey letters, grievance procedures, notices posted in service locations concerning grievances or notices included in program brochures or, if possible, interviews by the monitor with a number of clients concerning their satisfaction with services being provided): _____

_____

_____

_____

6. Are client rights posted? Yes _____ No _____

Where?_____

_____

7. Does the program/service provider have procedure in place to ensure that only assessed clients are served in the program (Congregate – NAPIS short assessment/HDM-Compass long assessment)?

Yes _____ No _____

Documentation (screening instruments, written procedures for establishing eligibility):

_____

_____

_____

8. Does the program/service provider have in place a system for referring clients to other services when a need for such services is identified (both Congregate and HDM)?

Yes _____ No _____

If yes, briefly describe system: _____

_____

_____

_____

9. Has the contractor informed each participant of the opportunity to make a voluntary anonymous contribution for congregate meals? Yes _____ No _____

_____

_____

_____

How often? _____

10. Does the contractor understand he/she may not impose a means test of eligibility and that no income or asset information may be used to determine eligibility for services?

Yes _____ No _____

10a. Is this policy carried out? Yes _____ No _____

How? _____

_____

_____

11. <u>FOR CONGREGATE SERVICES:</u>

For Congregate Services, is there a sign posted stating the suggested amount of the voluntary contribution? _____

Date:_____ Total Contribution Collected: $_____ Reported to Fiscal:_____

Congregate: $_____ Homebound: $_____Guest: $_____

11a. What is the suggested voluntary contribution amount? _____

11b. Does the sign give credit to the appropriate funding sources? ____Yes ____ No

11c. Does the sign: state the actual cost of the meal? ____Yes ____No

state the price of the meal for guests? ____Yes ____No
(actual cost of meal/see contract)

voluntary anonymous contribution amount ____ Yes ____No
(suggested)

11d. Are the above prices posted near the locked box? ____Yes ____No

11e. Are contributions deposited by participants into a locked box? ____Yes ____No

11f. Are envelopes provided to protect confidentiality of contributions? ____Yes ____No

12. HOME DELIVERED SERVICES:

12a. Attach a copy of any written material used to inform participants of the opportunity to make a voluntary contribution (HDM programs). Does this written material state:

_____Yes _____No voluntary and anonymous
_____Yes _____No no one is denied service because unable or unwilling
_____Yes _____No all contributions are used to expand the service
_____Yes _____No opportunity to make comments on the quality of service

12b. What is the suggested contribution amount? _____

12c. Does the program have a waiting list for home delivered meals?

Yes _____ No _____

If yes, please indicate the number of clients currently awaiting services and any efforts to refer clients to other service providers:

Service_____# of people on waiting list_____

Referring clients to other programs/providers: _____

_____

_____

_____

Vehicle Mileage Report

SITES	Vehicle	Serial number	Jan	Vehicle Condition	Feb	Vehicle Condition	March	Vehicle Condition	April	Vehicle Condition	May	Vehicle Condition	June	Vehicle Condition	Projected Year To Replace Vehicle
			July	Vehicle Condition	Aug	Vehicle Condition	Sept	Vehicle Condition	Oct	Vehicle Condition	Nov	Vehicle Condition	Dec	Vehicle Condition	

Additions/Deletions/Explanations:

Director's Signature

Date Completed

Vehicle Monitoring Report

Suffolk County Office for the Aging

Vehicle Monitoring Report

Agency: _____ Date: _____

Address: _____ Contact: _____

_____ Phone: _____

_____ E-Mail: _____

Date of Monitoring: _____

Vehicle Make/Model: _____

Vehicle VIN #: _____

License Plate #: _____

Current Mileage: _____

Decal – Yes/No: _____ Which Decal: _____

Overall Condition (i.e. accidents not reported etc.): _____

_____

_____

Vehicle Inspection Date (Sticker): _____

Vehicle Registration Expiration Date and Copy: _____

Vehicle ID Card & Copy: _____

Vehicle Used For: _____

_____

_____

Signature of Person Completing Information: _____

_____

(Print Name)

5/29/15

Availability of CPR Poster

Availability of CPR Equipment

In the event of an emergency call 911
or _____ at _____

Insert name of local emergency medical services (EMS)

Insert phone number of local EMS system

Resuscitation masks and disposable gloves are available at _____

Insert name of location where resuscitation equipment is provided

Learn CPR. For more information contact

_____

Insert name(s) of organization(s) qualified to offer CPR training,
which may include but are not limited to American Red Cross and American Heart Association.

- 10 NYCRR Part 801

1620

New York State Department of Health

Client Intake Form

INTAKE INFORMATION

A. Person's Name:

B. Address:

C. Phone #: DOB/Age:

D. Date of Referral: ____/____/____ FRAIL/DISABLED? YES NO
LIVES ALONE? YES NO

E. Referral Source (specify Name, Agency, Phone: _____

_____

F. Presenting Problem/Person's Concern(s): _____

_____

G. Has this person ever received meals from us? YES NO If YES, when? _____

H. Does the person know that a referral has been made? YES NO If not, why? _____

_____

I. Emergency Contact:
Name: _____ Phone: _____

Address: _____ Relationship: _____

J. Doctor's Name: _____

K. Dietary Restrictions:

None Diabetic Low Salt Other: _____

L. Has a physician prescribed this special diet? YES NO

M. Meal Plan: M-F S&S (H&C Hot only)

N. Assessment Date: _____

O. Start Date: _____

P. Six month contact due date: _____

Directions to house: _____

Intake Worker's Name: _____

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.

04/27/00

Comprehensive Assessment Form (COMPASS)

2016 NY COMPASS

Intake Information

Intake

Enter the date that the client was referred to the program.

____/____/_____

Enter Referral Source

- [ ] Adult Daughter
- [ ] Adult Day Health Care Center
- [ ] Adult Son
- [ ] Area Agency on Aging
- [ ] Community Care Facility
- [ ] Conservator
- [ ] County Eligibility Worker
- [ ] County Social Service Worker
- [ ] Early Hospital Discharge (Diagnostically Related Groups)
- [ ] Father
- [ ] Friend
- [ ] Guardian
- [ ] Health Services Department
- [ ] Home Health Agency
- [ ] Hospital Discharge Planner
- [ ] Housing Manager
- [ ] Intermediate Care Facility Discharge Planner
- [ ] Law Enforcement
- [ ] Linkages Program
- [ ] Medical Review (AB 3398)
- [ ] Mental Health Department
- [ ] Mother
- [ ] Multipurpose Senior Services Center
- [ ] Neighbor
- [ ] Nutrition Center
- [ ] Other
- [ ] Other Community Agency
- [ ] Other Relative
- [ ] Physician
- [ ] Pre-Admission Screening/Gatekeeper
- [ ] Regional Center
- [ ] Rehabilitation Department
- [ ] Religious Organization
- [ ] Reported Adult Abuse
- [ ] Self
- [ ] Senior Center
- [ ] Senior Day Care Center
- [ ] Skilled Nursing Facility Discharge Planner
- [ ] Social Security Administration
- [ ] Spouse
- [ ] Unknown

Which Services Has the Initial Contact Requested and What Is the Apparent Problems / Needs of the Client?

_____

_____

_____

_____

Does the client know that a referral has been made?

- [ ] No
- [ ] Yes

If the client is not aware of referral then describe why not.

_____

_____

_____

_____

Case Identification

Identification

What is the client's case record number?

_____

What is the date intake?

____/____/_____

What is the name of the person conducting this assessment?

_____

What is the email address of the person conducting this assessment?

_____

What is the name of the agency the assessor works for?

_____

Specify the type of assessment, or the reason for the assessment.

- ☐ Initial assessment
- ☐ Reassessment

What is the date of the client's next assessment?

____/____/_____

I. Client Information

I General Client Information

What is the client's last name?

_____

What is the client's first name?

_____

What is the client's middle initial?

_____

Enter the client's name suffix.

_____

Enter the client's residential street address or Post Office box.

_____

Enter the client's residential city or town.

_____

Enter the client's state of residence.

_____

Enter the client's residential zip code.

_____

Enter the client's telephone number.

_____

What is the client's cell phone number?

_____

What is the client's e-mail address?

_____

What is the client's Pension/Social Security Number?

_____-_____-_____

Select the client's current marital status.

- ☐ Divorced
- ☐ Domestic Partner or Significant Other
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

What was your sex at birth (on your original birth certificate)?

- ☐ Female
- ☐ Male

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person, born into a male body, but who feels female, or lives as a woman. Do you consider yourself to be transgender?

- ☐ No
- ☐ Yes, transgender, male to female
- ☐ Yes, transgender female to male
- ☐ Yes, transgender, do not identify as male or female
- ☐ Did Not Answer

What is the client's date of birth?

____/____/_____

Enter the age of the client in years.

☐

What is the client's race?

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/Non-Hispanic
- ☐ Hispanic
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other Race
- ☐ Two or More Races
- ☐ Unknown
- ☐ White (Alone) Hispanic
- ☐ White, Not Hispanic

What is the client's ethnicity?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Do you think of yourself as:

- ☐ Heterosexual or Straight
- ☐ Homosexual or Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Did Not Answer
- ☐ Not Sure
- ☐ Other

What is the client's creed or religion?

- [ ] Christianity
- [ ] Islam
- [ ] Hinduism
- [ ] Buddhism
- [ ] Judaism
- [ ] Did Not Answer
- [ ] Other

What is the client's nationality?

- [ ] Afghan
- [ ] Albanian
- [ ] Algerian
- [ ] American
- [ ] Andorran
- [ ] Angolan
- [ ] Antiguan
- [ ] Argentinean
- [ ] Armenian
- [ ] Australian
- [ ] Austrian
- [ ] Azerbaijani
- [ ] Bahamian
- [ ] Bahraini
- [ ] Bangladeshi
- [ ] Barbadian
- [ ] Barbudans
- [ ] Belarusian
- [ ] Belgian
- [ ] Belizean
- [ ] Beninese
- [ ] Bhutanese
- [ ] Bolivian
- [ ] Bosnian
- [ ] Botswana
- [ ] Brazilian
- [ ] British
- [ ] Bruneian
- [ ] Bulgarian
- [ ] Burkinabe
- [ ] Burmese
- [ ] Burundian
- [ ] Cambodian
- [ ] Cameroonian
- [ ] Canadian
- [ ] Cape Verdean
- [ ] Central African
- [ ] Chadian
- [ ] Chilean
- [ ] Chinese
- [ ] Colombian
- [ ] Comorians
- [ ] Congolese
- [ ] Costa Rican
- [ ] Croatian
- [ ] Cuban
- [ ] Cypriot
- [ ] Czechs
- [ ] Danes
- [ ] Djiboutians
- [ ] Dominican Republic
- [ ] Dutch
- [ ] East Timorese
- [ ] Ecuadorian
- [ ] Egyptians
- [ ] Emiratis
- [ ] Equatorial Guineans
- [ ] Eritreans
- [ ] Estonians
- [ ] Ethiopians
- [ ] Fijian
- [ ] Filipino
- [ ] Finns
- [ ] French
- [ ] Gabonese
- [ ] Gambians
- [ ] Georgians
- [ ] German
- [ ] Ghanaians
- [ ] Greeks
- [ ] Grenadians
- [ ] Guatemalan
- [ ] Guinea-Bissauans
- [ ] Guinean
- [ ] Guyanese
- [ ] Haitians
- [ ] Herzegovinian
- [ ] Honduran
- [ ] Hungarians
- [ ] Icelanders
- [ ] I-Kiribati
- [ ] Indians
- [ ] Inodnesian
- [ ] Iranians
- [ ] Iraqis
- [ ] Irish
- [ ] Israelis
- [ ] Italian
- [ ] Ivoirians
- [ ] Jamaicans
- [ ] Japanese
- [ ] Jordanians
- [ ] Kazakhs

What is the client's nationality?

- [ ] Kenyans
- [ ] Kittian and Nevisian
- [ ] Kuwaitis
- [ ] Kyrgyz
- [ ] Laotian
- [ ] Latvians
- [ ] Lebanese
- [ ] Liberians
- [ ] Libyans
- [ ] Liechtensteiners
- [ ] Lithuanians
- [ ] Luxembourgeois
- [ ] Macedonian
- [ ] Malagasy
- [ ] Malawians
- [ ] Malaysian
- [ ] Maldivians
- [ ] Malians
- [ ] Maltese
- [ ] Marshallese
- [ ] Mauritanian
- [ ] Mauritians
- [ ] Mexican
- [ ] Micronesians
- [ ] Moldovans
- [ ] Monacan
- [ ] Mongolians
- [ ] Moroccans
- [ ] Mosotho
- [ ] Motswana
- [ ] Mozambicans
- [ ] Namibians
- [ ] Nauruan
- [ ] Nepalese
- [ ] New Zealanders
- [ ] Nicaraguan
- [ ] Nigerians
- [ ] Nigerien
- [ ] North Korean
- [ ] Northern Irish
- [ ] Norwegians
- [ ] Omanis
- [ ] Pakistani
- [ ] Palauans
- [ ] Panamanian
- [ ] Papau New Guineans
- [ ] Paraguayan
- [ ] Peruvian
- [ ] Poles
- [ ] Portuguese
- [ ] Qataris
- [ ] Reported Multiple
- [ ] Romanians
- [ ] Russian
- [ ] Rwandans
- [ ] Saint Lucian
- [ ] Salvadoran
- [ ] Samoan
- [ ] San Marinese
- [ ] Sao Tomean
- [ ] Saudis
- [ ] Scots
- [ ] Senegalese
- [ ] Serbs
- [ ] Seychellois
- [ ] Sierra Leoneans
- [ ] Singaporeans
- [ ] Slovaks
- [ ] Slovenes
- [ ] Solomon Islander
- [ ] Somalis
- [ ] South Africans
- [ ] South Korean
- [ ] Spanish
- [ ] Sri Lankan
- [ ] Sudanese
- [ ] Surinamer
- [ ] Swazis
- [ ] Swedes
- [ ] Swiss
- [ ] Syrians
- [ ] Taiwanese
- [ ] Tajiks
- [ ] Tanzanians
- [ ] Thai
- [ ] Togolese
- [ ] Tongan
- [ ] Trinidadian or Tobagonian
- [ ] Tunisians
- [ ] Turks
- [ ] Tuvaluans
- [ ] Ugandans
- [ ] Ukrainian

What is the client's nationality?

- [ ] Uruguayan
- [ ] Uzbeks
- [ ] Venezuelan
- [ ] Vietnamese
- [ ] Welsh
- [ ] Yemenis
- [ ] Zambabweans
- [ ] Zambians

Client speaks English as primary language and does NOT have a limited ability to read, speak, write or understand English.

- [ ] No
- [ ] Yes

Specify the client's primary language.

- [ ] Chinese
- [ ] English
- [ ] French\Haitian Creole
- [ ] Italian
- [ ] Korean
- [ ] Other
- [ ] Russian
- [ ] Spanish

If not in the standard list, please specify or describe the client's primary language.

_____

Select the client's current living arrangement.

- [ ] Lives Alone
- [ ] Lives with Spouse Only
- [ ] Lives with Spouse and others
- [ ] Lives with Relatives (Excludes Spouse)
- [ ] Lives with Non-Relative(s), Domestic Partner
- [ ] Other

During the last 6 months, have you experienced any of the following forms of abuse?

- [ ] Active and Passive Neglect
- [ ] Domestic Violence
- [ ] Emotional Abuse
- [ ] Financial Exploitation
- [ ] None Reported
- [ ] Other (e.g. Abandonment)
- [ ] Physical Abuse
- [ ] Self Neglect
- [ ] Sexual Abuse

The month and year of the Elder Abuse service.

____/____/_____

To which organization was Elder Abuse referred to?

- [ ] AAA
- [ ] Adult Protective Services
- [ ] Domestic Violence Service Provider
- [ ] Not Referred
- [ ] Other
- [ ] Police Agency

Is the client frail?

- [ ] No
- [ ] Yes

Is the consumer disabled?

- [ ] No
- [ ] Yes

Primary Emergency Contact Name:

_____

Primary Emergency Contact Address:

_____

What is the emergency contact's city or town?

_____

What is the emergency contact's county?

_____

What is the emergency contact's state?

_____

What is the emergency contact's ZIP code?

_____

Relationship of Primary Emergency Contact to the client:

_____

Primary Emergency Contact Home Phone Number:

_____

Primary Emergency Contact Work Phone Number:

_____

Primary Emergency Contact Cell Phone Number:

_____

Secondary Emergency Contact Name:

_____

Secondary Emergency Contact Address:

_____

_____

_____

_____

Relationship of the Secondary Emergency Contact to the client:

_____

Secondary Emergency Contact Home Phone Number:

_____

II. Housing Status

II Housing

Does client live with Single Family or Multi-Family?

- [ ] Multi-Unit Housing
- [ ] Single Family Home

Does the client own or rent his/her residence?

- [ ] Owns
- [ ] Rents
- [ ] Other

Is the client a disabled veteran?

- [ ] No
- [ ] Unknown
- [ ] Yes

Specify which of the following conditions make the client's home environment hazardous or uninhabitable.

- [ ] Accumulated garbage
- [ ] Bad odors
- [ ] Carbon monoxide detector not present/not working
- [ ] Dangerous pet
- [ ] Doorway widths are inadequate
- [ ] Floors and stairways dirty and cluttered
- [ ] Loose scatter rugs present in one or more rooms
- [ ] No lights in the bathroom or in the hallway
- [ ] No handrails on the stairway
- [ ] No lamp or light switch within easy reach of the bed
- [ ] No locks on doors or not working
- [ ] No grab bar in tub or shower
- [ ] No rubber mats or non-slip decals in the tub or shower
- [ ] No running water
- [ ] Smoke detectors not present/not working
- [ ] Stairs are not lit
- [ ] Stairways are not in good condition
- [ ] Telephone and appliance cords are strung across areas where people walk
- [ ] Traffic lane from the bedroom to the bathroom is not clear of obstacles
- [ ] Other

Is safety in the client's neighborhood an issue?

- [ ] Yes
- [ ] No

How many people reside in the client's household, including the client?

Enter the client's total monthly housing expenses. (Only if EISEP eligible)

$

III. Health Status

III Health

What is the name of the client's primary care physician?

_____

What is the name of the client's Clinic/HMO?

_____

_____

_____

_____

What is the name of the client's Primary Hospital?

_____

What is the date of the client's last visit to primary medical provider?

____/____/_____

Does the client have any of the following self-declared chronic illnesses and/or disabilities? (Check all that apply)

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anorexia
- ☐ Appetite Impairment
- ☐ Arthritis
- ☐ Cancer
- ☐ Cellulitis
- ☐ Chewing Difficulties
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic pain
- ☐ Colitis
- ☐ Colostomy
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ Decubitus Ulcers
- ☐ Dehydration
- ☐ Dental Problems
- ☐ Developmental Disabilities
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Diverticulitis
- ☐ Fractures (Recent)
- ☐ Frequent Falls
- ☐ Gall Bladder Disease
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol * (may indicate need for assessment by nutritionist)
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Incontinence
- ☐ Legally blind
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Oxygen Dependent
- ☐ Paralysis
- ☐ Parkinson's
- ☐ Pernicious anemia
- ☐ Renal Disease
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Smelling Impairment
- ☐ Speech Problems
- ☐ Stroke
- ☐ Swallowing Difficulties
- ☐ Taste Impairment
- ☐ Traumatic brain injury
- ☐ Tremors
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Visual Impairment
- ☐ Other
- ☐ Other - Nutrition Problem

Comments regarding Other Medical Conditions

_____

Which of the following assistive devices, if any, does the client use? (Check all that apply)

- ☐ Accessible vehicle
- ☐ Bath Chair
- ☐ Bed rail
- ☐ Cane
- ☐ Commode
- ☐ Communication Device
- ☐ Crutches
- ☐ Dentures - Full
- ☐ Dentures - Partial
- ☐ Feeding Utensils
- ☐ Glasses
- ☐ Grab bars
- ☐ Hand held shower
- ☐ Hearing Aid
- ☐ Hoyer lift
- ☐ Lift chair
- ☐ Oxygen
- ☐ PERS
- ☐ Raised toilet seat
- ☐ Scooter
- ☐ Stair lift
- ☐ Tub seat
- ☐ Walker
- ☐ Wheelchair/Transportable folding
- ☐ Other

Does the client need an Assistive Device?

- ☐ No
- ☐ Yes

If needed, what type of Assistive Device does the client require?

_____

Does the client/caregiver need training on the use of an Assistive Device?

- ☐ No
- ☐ Yes

If training is needed, describe the type of training the client/caregiver needs on the use of an Assistive Device.

_____

_____

_____

_____

Has the client been hospitalized in the past six months?

- ☐ No
- ☐ Yes

How many hospital visits has the patient made (Hospital or Emergency Room) in the last six (6) months?

Enter the Start and End Date, Event Type and Description. Under Event type, enter Hospital Visit or Emergency Room.

Start Date	End Date	Event Type	Description

For what reason(s) did the client seek emergent care?

- ☐ Cardiac problems
- ☐ Chemotherapy
- ☐ Deep vein thrombosis, pulmonary embolus
- ☐ GI bleeding or obstruction
- ☐ Hypo/hyperglycemia or diabetes
- ☐ Injury caused by fall or accident
- ☐ IV catheter-related infection
- ☐ Medication
- ☐ Myocardial infarction, stroke
- ☐ Nausea, dehydration, malnutrition, constipation, impaction
- ☐ Other than above
- ☐ Psychotic episode
- ☐ Respiratory problems
- ☐ Scheduled surgical procedure
- ☐ Uncontrolled pain
- ☐ Unknown
- ☐ Urinary tract infection
- ☐ Wounds

What assessment types have been completed with the client?

- ☐ DSM1 - Mental Health
- ☐ PRI - Nursing Home

What is the date that the assessment was signed as complete?

____/____/_____

What is the assessment score?

III Alcohol Screening Test - The CAGE Questionnaire

Have you ever felt you should cut down on your drinking?

- ☐ No
- ☐ Yes

Have people annoyed you by criticizing your drinking?

- ☐ No
- ☐ Yes

Have you ever felt bad or guilty about your drinking?

- ☐ No
- ☐ Yes

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

- ☐ No
- ☐ Yes

IV. Nutrition

IV BMI

What is the client's height in inches?

What is the client's weight in pounds?

What is the client's body mass index (BMI)? Take weight in pounds and multiply by 703. Divide that number by height in inches, then divide by height in inches again. Healthy, older adults should have a BMI between 22 and 27.

What is the client's Body Mass Index (BMI)?

IV General Nutrition

Are the client's refrigerator/freezer and cooking facilities adequate?

- [ ] No
- [ ] Yes

Is the client able to open containers/cartons and cut up food?

- [ ] No
- [ ] Yes

Does the client have a physician prescribed modified/therapeutic diet?

- [ ] No
- [ ] Yes

Describe the client's physician prescribed modified/therapeutic diet.

- [ ] Calorie Controlled
- [ ] Diabetic diet
- [ ] Fat Restricted
- [ ] General
- [ ] High Calorie
- [ ] Liquid nutritional supplement
- [ ] Other
- [ ] Renal
- [ ] Sodium Restricted
- [ ] Texture Modified

Describe the client's non-physician prescribed modified/therapeutic diet.

- [ ] 6 small meals daily
- [ ] Ethnic/Religious
- [ ] Modified
- [ ] Regular
- [ ] Therapeutic
- [ ] Unspecified
- [ ] Vegetarian

Describe the client's special diet(s).

Does the client have a physician-diagnosed food allergy?

- [ ] No
- [ ] Yes

Does the client use dietary supplements or aids that have been recommended by someone who provides alternative medical care?

- [ ] No
- [ ] Yes

List the dietary supplements or aids taken by the client.

IV Nutritional Risk Status: NSI Self Calculating Risk Assessment *Must Answer All Questions*

Have illness or conditions made the client change the kind and/or amount of food eaten?

- [ ] No
- [ ] Yes

Does the client eat fewer than 2 meals per day?

- [ ] No
- [ ] Yes

Does the client eat few (less than 5) vegetables or fruits, or milk products per day?

- [ ] No
- [ ] Yes

Does the client have 3 or more drinks of beer, liquor or wine almost every day?

- [ ] No
- [ ] Yes

Does the client have tooth or mouth problems that make it hard for him/her to eat?

- [ ] No
- [ ] Yes

Does the client sometimes not have enough money to buy food?

- [ ] No
- [ ] Yes

Does the client eat alone most of the time?

- [ ] No
- [ ] Yes

Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- [ ] No
- [ ] Yes

Without wanting to, has the client lost or gained 10 pounds in the past 6 months?

- [ ] No
- [ ] Yes

Is the client not always physically able to shop, cook and/or feed themselves?

- [ ] No
- [ ] Yes

What is the client's nutritional risk score?

What is the client's nutritional risk score rating?

- [ ] High risk (6-21)
- [ ] Moderate risk (3-5)
- [ ] No risk (0-2)

V. Psycho-Social Status

V Psycho-Social

Does the person appear, demonstrate and/or report an of the following? (Check all that apply)

- [ ] Alert
- [ ] Cooperative
- [ ] Dementia
- [ ] Depressed
- [ ] Disruptive socially
- [ ] Hallucinations
- [ ] Hoarding
- [ ] Impaired decision making
- [ ] Lonely
- [ ] Memory deficit
- [ ] Physical aggression
- [ ] Self neglect
- [ ] Sleeping problems
- [ ] Suicidal behavior
- [ ] Suicidal thoughts
- [ ] Verbal disruption
- [ ] Worried or anxious
- [ ] Other

Is there evidence that the client has problems with substance abuse?

- [ ] No
- [ ] Yes

Has problem behavior been reported?

- [ ] No
- [ ] Yes

Has the client been diagnosed with mental health problems?

- [ ] No
- [ ] Yes

In the past year, has the client received (or is the client currently receiving) mental health treatment or counseling?

- [ ] No
- [ ] Yes

Does it appear that the client needs a mental health evaluation?

- [ ] No
- [ ] Yes

Comments regarding Mental Health Condition:

VI. Prescribed & Over the Counter Medications Currently Taken

VI Medication

List all prescribed and non prescribed medications taken by the client in the last 7 days.

Name and Dose: Record the name of the medication and dose ordered.

Unit type: gtts (Drops) Puffs; mEq (Milli-equivalent); gm (Gram) (Percentage); mg (Milligram); %

Form: Code the route of administration using the following list:

1 = by mounth (PO)	7 = topical
2 = sub lingual (SL)	8 = inhalation
3 = intramuscular (IM)	9 = enteral tube
4 = intravenous (IV)	10 = other
5 = subcutaneous (SQ)	11 = eye drop
6 = rectal (R)	12 = transdermal

Frequency: Code the number of times per period the med is administered using the following list:

PR = (PRN) as necessary	OO = every other day
1H = (QH) every hour	1W = (Q week) once each week
2H = (Q2H) every 2 hours	2W = 2 times every week
3H = (Q3H) every 3 hours	3W = 3 times every week
4H = (Q4H) every 4 hours	4W = 4 times each week
6H = (Q6H) every 6 hours	5W = 5 times each week
8H = (Q8H) every eight hours	6W = 6 times each week
1D = (QD or HS) once daily	1M = (Q month) once/mo.
2D = (BID) two times daily *(includes every 12 hours)*	2M = twice every month
	C = Continuous
3D = (TID) 3 times daily	O = Other
4D = (QID) four times daily	
5D = 5 times daily	

Name	Dose	Form	Freq.	PRN	# Taken	Drug Code	Comments

What is the name of the client's Pharmacy?

What is the telephone number of the client's Pharmacist?

Does the client have any problems with taking medications as instructed / prescribed?

- [ ] No
- [ ] Yes

Does the client have any adverse reactions/allergies/sensitivities to his/her medications?

- [ ] No
- [ ] Yes

Does the client have trouble obtaining or paying for his/her medications?

- [ ] No
- [ ] Yes

Comments on Medications

VII. IADLs

VII IADLs Self Calculating Score *Must answer ALL questions other than Comments.*

Specify the client's ability to perform HOUSEWORK/CLEANING.

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are housework needs currently met (at time of assessment)?

- ☐ No
- ☐ Yes

What support is used to meet housework needs?

- ☐ Both
- ☐ Formal Support
- ☐ Informal Support

Comment on the client's ability to do ordinary housework.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Shopping needs currently met (at time of assessment)?

- ☐ No
- ☐ Yes

What support is used to meet Shopping needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to do shopping.

Describe the client's ability to do his or her own LAUNDRY.

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help wthl all or most of task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Laundry needs currently met (at time of assessment)?

- ☐ No
- ☐ Yes

What supports are used to meet Laundry needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to do laundry.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Transportation needs currently met (at time of assessment)?

- ☐ No
- ☐ Yes

What supports are used to meet Transportation needs?

- ☐ Both
- ☐ Formal Support
- ☐ Informal Support

Comment on the client's ability to use transportation.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Meal Preparation Performance Needs Currently met?

- ☐ No
- ☐ Yes

What support is used to meet Meal preparation performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to prepare meals.

Specify the client's ability to MANAGE MONEY.

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspect of task

Are Money management needs currently met?

- ☐ No
- ☐ Yes

What support is used to meet Money Management needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to manage money.

Rank the client's ability to use the TELEPHONE.

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are telephone use performance needs currently met?

- ☐ No
- ☐ Yes

What supports are used to meet telephone use performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to use the telephone.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspect of task

Are Managing Medication performance needs currently met?

- ☐ Need unmet
- ☐ No
- ☐ Yes

What support is used to meet Managing medications performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to take his/her medication.

Are changes in the IADL functionality capacity expected in the next 6 months?

- ☐ No
- ☐ Yes

What is the client's IADL count?

VIII. ADLs

VIII ADLs Self Calculating Score "Must answer ALL questions other than Comments.*

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Bathing performance needs currently met?

- ☐ No
- ☐ Yes

What support is used to meet Bathing performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to bathe him/herself.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform PERSONAL HYGIENE?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Personal Hygiene performance needs currently met?

- ☐ No
- ☐ Yes

What supports are used to meet Personal Hygiene performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to groom him/herself.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Dressing performance needs currently met?

- ☐ No
- ☐ Yes

What support is used to meet Dressing performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to dress him/herself.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are walking in home performance needs currently met?

- ☐ No
- ☐ Yes

What supports are used to meet walking in home performance needs?

- ☐ Formal supports
- ☐ Informal supports
- ☐ Both

Comment on the client's ability to get around inside the home.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspect of task

Are Transfer performance needs currently met?

- ☐ No
- ☐ Yes

What support is used to meet Transfer performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Enter any comments regarding the client's ability to transfer.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspects of task

Are Toilet Use performance needs currently met?

- ☐ No
- ☐ Yes

What support is used to meet Toilet Use performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to use the toilet.

During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- ☐ 1 = Totally Able
- ☐ 2 = Requires intermittent supervision and/or minimal assistance
- ☐ 3 = Requires continual help with all or most of this task
- ☐ 4 = Person does not participate; another person performs all aspect of task

Are Eating performance needs currently met?

- ☐ No
- ☐ Yes

What supports are used to meet Eating performance needs?

- ☐ Both
- ☐ Formal Supports
- ☐ Informal Supports

Comment on the client's ability to eat.

Are changes in the ADL functional capacity expected in the next 6 months?

- ☐ No
- ☐ Yes

What is the client's ADL count?

IX. Services Client Currently Receiving

IX Services

Is the client participating in any of the following services or programs? (Check all that apply)

- [ ] Adult Day Health Care
- [ ] Assisted Transportation
- [ ] Caregiver Support
- [ ] Case Management
- [ ] Community Based Food Program
- [ ] Congregate Meals
- [ ] Consumer Directed In-Home Services
- [ ] Equipment/Supplies
- [ ] Friendly Visitor/Telephone Assistance
- [ ] Health Promotion
- [ ] HIICAP - Health Insurance Counseling
- [ ] Home Delivered Meals
- [ ] Home Health Aide
- [ ] Hospice
- [ ] Housing Assistance
- [ ] Legal Services
- [ ] Mental Health Services
- [ ] None utilized
- [ ] Nutritional Counseling
- [ ] Occupational Therapy
- [ ] Other
- [ ] Outreach
- [ ] Personal Care Level I
- [ ] Personal Care Level II
- [ ] PERS - Personal Emergency Response System
- [ ] Physical therapy
- [ ] Protective Services
- [ ] Respiratory Therapy
- [ ] Respite
- [ ] Senior Center
- [ ] Senior Companions
- [ ] Services for the Blind
- [ ] Shopping
- [ ] Skilled Nursing
- [ ] Social Adult Day Care
- [ ] Speech Therapy
- [ ] Transportation

Please specify other services or programs the client is participating in.

X. Informal Support Status

X Primary Informal Support

Does the client have a family member, friend, or neighbor who helps him/her on a regular basis?

- [ ] No
- [ ] Yes

What is the first name of the client's primary informal support?

_____

What is the last name of the client's primary informal support?

_____

What is the relationship of the primary informal support to the client?

- [ ] Agency
- [ ] Agent
- [ ] Aunt
- [ ] Brother
- [ ] Brother-in-law
- [ ] CHHA
- [ ] Cousin
- [ ] Daughter
- [ ] Daughter-in-law
- [ ] Doctor
- [ ] Domestic Partner
- [ ] Family
- [ ] Father
- [ ] Father-in-law
- [ ] Friend
- [ ] Granddaughter
- [ ] Grandfather
- [ ] Grandmother
- [ ] Grandson
- [ ] Hospital
- [ ] Husband
- [ ] Landlord
- [ ] Medicaid
- [ ] Mother
- [ ] Mother-in-law
- [ ] Neighbor
- [ ] Nephew
- [ ] Niece
- [ ] None Exists
- [ ] Officials
- [ ] Other
- [ ] Owner
- [ ] Relative
- [ ] Religious Org
- [ ] Self
- [ ] Sister
- [ ] Sister-in-law
- [ ] Social Serv. Agc
- [ ] Social Worker
- [ ] Son
- [ ] Son-in law
- [ ] Stepdaughter
- [ ] Stepfather
- [ ] Stepmother
- [ ] Stepson
- [ ] Super
- [ ] Uncle
- [ ] Visiting Nurse
- [ ] Wife

What is the home phone number of the client's primary informal support?

_____

What is the work phone number of the client's primary informal support?

_____

What is the cell phone number of the client's primary informal support?

_____

What is the email address of the client's primary informal support?

_____

_____

_____

_____

Describe the type of help provided by the client's primary informal support.

_____

_____

_____

_____

How many hours a day does the client's primary caregiver usually spend caring for the client?

Does the client have a good relationship with his/her primary caregiver?

- [ ] No
- [ ] Yes

Would the client accept help/more help from his/her primary caregiver to remain at home and/or maintain independence?

- [ ] No
- [ ] Yes

What are some of the factors that might limit the primary caregiver?

- [ ] Emotional burden
- [ ] Family responsibilities
- [ ] Finances
- [ ] Health problems
- [ ] Job
- [ ] Other
- [ ] Physical burden
- [ ] Reliability

Does the client's primary caregiver desire service or support?

- [ ] No
- [ ] Yes

When does the primary caregiver need relief?

- [ ] Afternoon
- [ ] Evening
- [ ] Morning
- [ ] Other
- [ ] Overnight
- [ ] Weekend

Would the primary informal support contact be considered the caregiver?

- [ ] Don't Know
- [ ] No
- [ ] Yes

Services provided as respite to the caregiver (informal support primary)

- [ ] Adult Day Services
- [ ] In Home Contact & Support (Paid Supervision)
- [ ] Personal Care Level 1
- [ ] Personal Care Level 2

Info for primary caregiver about other services.

- [ ] Yes
- [ ] No
- [ ] Unknown

X Secondary Informal Support

What is the first name of the client's secondary informal support?

What is the client's secondary helper's last name.

What is the relationship of the secondary helper to the client?

- [ ] Agency
- [ ] Agent
- [ ] Aunt
- [ ] Brother
- [ ] Brother-in-law
- [ ] CHHA
- [ ] Cousin
- [ ] Daughter
- [ ] Daughter-in-law
- [ ] Doctor
- [ ] Domestic Partner
- [ ] Family
- [ ] Father
- [ ] Father-in-law
- [ ] Friend
- [ ] Granddaughter
- [ ] Grandfather
- [ ] Grandmother
- [ ] Grandson
- [ ] Hospital
- [ ] Husband
- [ ] Landlord
- [ ] Medicaid
- [ ] Mother
- [ ] Mother-in-law
- [ ] Neighbor
- [ ] Nephew
- [ ] Niece
- [ ] None Exists
- [ ] Officials
- [ ] Other
- [ ] Owner
- [ ] Relative
- [ ] Religious Org
- [ ] Self
- [ ] Sister
- [ ] Sister-in-law
- [ ] Social Serv. Agc
- [ ] Social Worker
- [ ] Son
- [ ] Son-in law
- [ ] Stepdaughter
- [ ] Stepfather
- [ ] Stepmother
- [ ] Stepson
- [ ] Super
- [ ] Uncle
- [ ] Visiting Nurse
- [ ] Wife

What is the client's secondary helper's home phone number.

_____

What is the client's secondary helper's work phone number.

_____

Secondary Emergency Contact Cell Phone Number:

_____

Secondary Helper Email

_____

_____

_____

_____

Describe the type of help provided by the client's secondary helper.

_____

_____

_____

_____

Does the client have a good relationship with his/her secondary caregiver?

- [ ] No
- [ ] Yes

Would the client accept help/more help from his/her secondary caregiver to remain at home and/or maintain independence?

- [ ] No
- [ ] Yes

Are there any factors that might limit the involvement of the client's secondary caregiver?

- [ ] Emotional Burden
- [ ] Family Responsibilities
- [ ] Finances
- [ ] Health Problems
- [ ] Job
- [ ] Other
- [ ] Physical Burden
- [ ] Reliability

Is Secondary Caregiver relief needed?

- [ ] No
- [ ] Yes

When does the secondary caregiver need relief?

- [ ] Afternoon
- [ ] Evening
- [ ] Morning
- [ ] Other
- [ ] Overnight
- [ ] Weekend

Would secondary helper be considered the caregiver?

- [ ] Don't Know
- [ ] No
- [ ] Yes

Services provided as respite to the caregiver (informal support secondary)

- [ ] Adult Day Services
- [ ] In Home Contact & Support (Paid Supervision)
- [ ] Personal Care Level 1
- [ ] Personal Care Level 2

Info for secondary caregiver about other services.

- [ ] Yes
- [ ] No
- [ ] Unknown

Does the client have any community, neighborhood or religious affiliations who could provide assistance?

- [ ] No
- [ ] Unknown
- [ ] Yes

Describe community, neighborhood or religious affiliations who could provide assistance and the type of assistance.

_____

_____

_____

_____

Specify overall evaluation of informal support system

- [ ] Adequate, Can Expand if needed
- [ ] Adequate, Could not expand
- [ ] Inadequate/Limited
- [ ] Other
- [ ] Temporarily Unavailable

XI. Monthly Income

XI Monthly Income

Specify the client's monthly social security income.

$

Specify the client's monthly Supplemental Security income.

$

Specify the client's monthly retirement/pension income.

$

Specify the client's monthly interest income.

$

What is the monthly income from dividends for the client?

$

Specify the client's monthly wage/salary/earnings income.

$

Specify the client's other monthly income.

$

Specify the client's monthly income.

$

Total Client Monthly Income

Specify the monthly social security income of the client's spouse.

$

Specify the monthly SSI income of the client's spouse.

$

Specify the monthly retirement/pension income of the client's spouse.

$

Specify the monthly interest income of the client's spouse.

$

Specify the monthly dividends income of the client's spouse.

$

Specify the monthly wage/salary/earnings income of the client's spouse.

$

Specify other monthly income of the client's spouse.

$

Total Spouse Monthly Income

Specify the monthly Social Security income of the client's other family members/household.

$

Specify the monthly SSI income of the client's other family members/household.

$

Monthly Retirement/Pension income of other family members residing with the Individual.

$

Specify the monthly interest income of the client's other family/household.

$

Specify the monthly dividends income of the client's other family members/household.

$

Specify the monthly wage/salary/earnings of the client's other familymembers/household.

$

Specify the monthly other income of the client's other family members/household.

$

Total Other Family Monthly Income

What is the total income of the client's household per month?

$

Total Household Monthly Income

Did the client refuse to give financial information?

- [ ] No
- [ ] Yes

100% Poverty Threshold

Is the client's income level at or below 100% of the poverty threshold?
Household Size = 1 / $11,880
Household Size = 2 / $16,020
Household Size = 3 / $20,160
Household Size = 4 / $24,300
Household Size = 5 / $28,440
Household Size = 6 / $32,580

- [ ] No
- [ ] Yes

150% Poverty Threshold

Is the client's income level at or below 150% of the poverty threshold?
Household Size = 1 / $17,820
Household Size = 2 / $24,030
Household Size = 3 / $30,240
Household Size = 4 / $36,450
Household Size = 5 / $42,660
Household Size = 6 / $48,870

- [ ] No
- [ ] Yes

Specify the client's overall cost share.

Is client EISEP eligible?

- [ ] No
- [ ] Yes

XII. Benefits/Entitlements

XII Income Related Benefits

Does the client receive Social Security?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Is the client Social Security Income (SSI) eligible?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client receive Railroad Retirement?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Is the client a veteran?

- [ ] Yes
- [ ] No
- [ ] Declined to Disclose
- [ ] Unknown

Does the client have VA Benefits?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and willing to pursue
- [ ] Refuses to provide information

XII Entitlements

Does the client receive Medicaid?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Enter the client's Medicaid number.

_____

Is the consumer eligible for Food Stamps?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue

Does the client receive Public Assistance?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

XII Health Related Benefits

Does the client have Elderly Pharmaceutical Coverage (EPIC) ?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Enter the food stamps entitlement the client currently receives.

$ _____

Does the client have health insurance?

- [ ] Declined to disclose
- [ ] May be eligible and is willing to pursue
- [ ] No
- [ ] Unknown
- [ ] Yes

Does the client have a Lifeline/PERS?

- [ ] No
- [ ] Yes

Does the client have a Private Health Insurance?

- [ ] Don't Know
- [ ] May be eligible and is willing to pursue
- [ ] No
- [ ] Yes

How much public assistance does the client receive each month?

$ _____

Does the client have a Qualified Medical Beneficiary (QMB)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Enter the amount of Section 8 entitlement the client receives.

$ _____

Does the client receive Social Security Disability?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client receive Medicare?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and willing to pursue
- [ ] Refuses to provide information

Enter the client's Medicare number.

_____

Does the client have a Specified Low Income Medicare Beneficiary (SLIMB)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client receive Medicare Part D?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] Refuses to provide information

Does the client have Medigap health insurance?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

What is the client's Medigap policy number?

_____

Does the client have LTC health insurance?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

What is the name of the client's LTC health insurer?

_____

_____

_____

_____

Does the client have Other health insurance?

- [ ] Yes
- [ ] No
- [ ] Don't know

Enter the name of the client's other health insurance carrier, if applicable.

_____

What is the name of the client's other health insurer?

_____

_____

_____

_____

XII Housing Related Benefits

Does the client have a Senior Citizen Rent Increase Exemption (SCRIE)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client file an IT214 Property Tax Rebate?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client receive a Veteran Tax Exemption?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client have a reverse mortgage?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Does the client receive a Real Property Tax Exemption (STAR)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Has the client applied for the Home Energy Assistance Plan (HEAP)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

Has the client had Weatherization, Referral and Packaging (WRAP)?

- [ ] Has the benefit/entitlement
- [ ] Does not have the benefit/entitlement
- [ ] May be eligible and is willing to pursue
- [ ] Refuses to provide information

XII Programs

Does the Client Participate in the following Programs?

- ☐ Community Living Program (CLP)
- ☐ Chronic Disease Self Management Program (CDSMP)
- ☐ Integrated Systems Grant Part A
- ☐ Other Programs as Defined by NYSOFA

XIII. Care Plan

XIII Care Plan

Is the client self-directing?

- ☐ No
- ☐ Yes

Describe the client's ability to direct home care staff.

_____

Describe the client's preference regarding the provision of services.

_____

Has the care plan been discussed and accepted by the client?

- ☐ No
- ☐ Yes

Comments related to the discussion and/or acceptance of the plan of care by the client and/or their informal supports.

_____

_____

_____

_____

XIV. Emergency Preparedness

XIV Subsection1

Does the person have an emergency/disaster safety plan?

- [ ] No
- [ ] Yes

Contact Person in the event of a disaster

Does the client have a reliable source of transportation?

- [ ] No
- [ ] Yes

Who is the client's provider contact for transportation services?

Does the customer's home have: electricity

- [ ] Does Not Have
- [ ] Not Working
- [ ] Working

Personal Care Needs Comments

Is the consumer self-sufficient in mobility?

- [ ] No
- [ ] Yes

Enter any additional comments regarding mobility.

Does the client use a wheelchair to get around?

- [ ] Don't know
- [ ] No
- [ ] Yes

Does the client have someone who does or is paid for doing yard work and snow removal?

- [ ] Client does it
- [ ] Client pays for it to be done
- [ ] Does not get done
- [ ] Family/others do it
- [ ] Not applicable

What is the name of the client's alternate contact?

Registered with County Special Needs?

- [ ] No
- [ ] Yes

Describe any other preferences or special needs.

Title :

Date

Title :

Date

NYSOFA 6 Month Form

Client Information

General Client Information

HDM Recipient 6 Month Contact Date

_____/_____/_____

What is the client's last name?

_____

What is the client's first name?

_____

What is the client's middle initial?

_____

Enter the client's name suffix.

_____

Enter the client's residential street address or Post Office box.

_____

Enter the client's residential city or town.

_____

Enter the client's state of residence.

_____

Enter the client's residential zip code.

_____

Enter the client's telephone number.

_____

What is the client's cell phone number?

_____

What is the client's e-mail address?

_____

Health Status

General Health Information

What is the date of the client's last visit to his/her primary medical provider?

_____/_____/_____

What was the reason for the last visit to his/her primary medical provider?

_____

Has the client experienced any changes regarding any of the following self-declared chronic illnesses and/or disabilities?

- [ ] (Deleted)
- [ ] Alcoholism
- [ ] Allergies
- [ ] Alzheimer's
- [ ] Amputation
- [ ] Anemia
- [ ] Anorexia
- [ ] Appetite Impairment
- [ ] Arthritis
- [ ] Bladder/Kidney problems
- [ ] Brain injury
- [ ] Cancer
- [ ] cellulitis
- [ ] Chewing Difficulties
- [ ] Chronic diarrhea
- [ ] chronic obstructive pulmonary disease (COPD)
- [ ] Chronic pain
- [ ] Cognitive Impairment
- [ ] Colitis
- [ ] Colostomy
- [ ] Congestive Heart Failure
- [ ] Constipation
- [ ] COPD
- [ ] decubitus ulcers
- [ ] Dehydration
- [ ] Dementia (other than Alzheimer's)
- [ ] Dental Problems
- [ ] developmental disabilities
- [ ] Diabetes
- [ ] dialysis
- [ ] Diarrhea
- [ ] Digestive Problems
- [ ] Diverticulitis
- [ ] Dizziness
- [ ] Falls in past year
- [ ] Fractures (Recent)
- [ ] Frequent Falls
- [ ] frequent falls
- [ ] Gall Bladder Disease
- [ ] Hearing Impairment
- [ ] Heart Disease
- [ ] Hiatal Hernia
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] high cholesterol * (may indicate need for assessment by nutritionist)
- [ ] HIV / AIDS
- [ ] Hoarding
- [ ] Huntington's Disease
- [ ] Hyperglycemia
- [ ] Hypertension
- [ ] Hypoglycemia
- [ ] Incontinence
- [ ] Legally blind
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Multiple Sclerosis
- [ ] Muscular dystrophy
- [ ] None
- [ ] Osteoporosis
- [ ] Other
- [ ] Other - Nutrition Problem
- [ ] Oxygen dependent
- [ ] Pacemaker
- [ ] Paralysis
- [ ] Paralysis
- [ ] Parkinson's
- [ ] Pernicious anemia
- [ ] Physically disabled
- [ ] Renal Disease
- [ ] Respiratory Problems
- [ ] Seizure disorders
- [ ] Shingles
- [ ] Sleep problems
- [ ] Smelling Impairment
- [ ] Speech Problems
- [ ] Stroke
- [ ] Swallowing Difficulties
- [ ] Taste Impairment
- [ ] Technology dependent
- [ ] Thyroid problems (Graves, Myxedema)
- [ ] Transplant
- [ ] Traumatic brain injury
- [ ] Tremors
- [ ] Ulcer
- [ ] Urinary Tract Infection
- [ ] Ventilation dependent
- [ ] Visual Impairment

Has the client experienced any changes in need for an Assistive Device/Adaptive Equipment?

- [ ] No
- [ ] Yes

What is the reason for Assistive Device/Adaptive Equipment that the client requires?

_____

Has the client been hospitalized in the past six months?

- ☐ No
- ☐ Unable to determine
- ☐ Yes

Why was client in the hospital?

_____

Has the client visited an emergency room in the past six months?

- ☐ No
- ☐ Yes

Describe the reasons the client visited the emergency room in the past 6 months.

_____

_____

_____

_____

Nutrition Status

General Nutrition Information

Has the client lost or gained weight in the past 6 months?

- ☐ Gained
- ☐ Lost
- ☐ No change or not applicable

What is the reason for the client's weight change in the past 6 months?

_____

_____

_____

_____

What is the client's body mass index (BMI)?

☐

Are the client's refrigerator/freezer and cooking facilities adequate?

- ☐ No
- ☐ Yes

Is the client able to open containers/cartons and cut up food?

- ☐ No
- ☐ Yes

Does the client take nutritional supplements?

- ☐ No
- ☐ Yes

Psycho-Social Status

General Psycho-Social Information

Have there been any mental status changes?

- [ ] No
- [ ] Yes

Has the consumer had a change in emotional status and behavior?

- [ ] No
- [ ] Yes

Medication Usage Status

General Medication Information

Why is the client taking prescribed and over the counter medications?

_____

_____

_____

_____

Does the client have any problems with taking medications as instructed / prescribed?

☐ No

☐ Yes

Title : _____ Date

Title : _____ Date

Six Month HDM Assessment Follow Up

* Key Areas to Cover

* Six Month Contact Form

AREAS TO BE COVERED DURING THE SIX-MONTH CONTACT FOR HOME DELIVERED MEAL CLIENTS

This contact must explore the nine areas listed below to determine if any changes have occurred since the last assessment. Starred items indicate possible problems to help the assessor identify c change.

1. **Health Status**
   - ❖ Ask date of last visit to primary medical provider and reason for visit.
   - ❖ As of status of chronic illnesses or self-declared disabilities-If client has been to his/her physician in the past six months, staff may want to contact the physician to further identify/confirm any changes in the client's physical health status the seems uncertain about.
   - ❖ Ask about change in need for assistive device and reason for device.
   - ❖ Ask of any hospitalization within the past six months and reason for adminission.
   - ❖ Ask of any emergency room visit within the past six months and the reason for visit.

2. **Nutrition (Status and Service)**
   Please ask each of the following items:
   a. Ask if meals are still needed.
   b. Ask about the adequacy of the meal service (quality, quantity, food preferences).
   c. Determine if there has been any unwanted weight change (i.e., at least 10 lbs. within the past 6 months). If unwanted change, ask current weight; calculate body mass index.
   d. Review adequacy of food storage and heating facilities (refrigerator/freezer, oven, stove top, microwave).
   e. Review ability to open HDM containers and cut up food.
   f. Determine if there has been a diet change.
   g. Determine if client continues to use or is now using nutritional supplements.

3. **Psycho-Social Status**

   - ❖ Indirectly evaluate through speaking with client about other items to determine if there has been a change.

4. **Medication Usage**
   Review medication/dosage changes if changes have been noted in health status, item #1.
   - ❖ Ask about prescribed and over the counter medications currently taken and any problems that the client may have with medications.
   - ❖ May want to contact the physician to further identify/confirm changes in the client's medications since information may be difficult to accurately obtain over the telephone.

5. **Instrumental Activities of Daily Living**

   Reference the most recent assessment to determine if there are any changes in the client's ability to perform any instrumental activities of daily living.

6. **Activities of Daily Living**

   Reference the most recent assessment to determine if there are any changes in the client's ability to perform any activities of daily living.

7. **Informal Support Status**

   - Verify continued involvement of informal caregivers.
   - Note any change in living arrangement, emergency contact.

8. **Services Client is Currently Receiving**

   - Confirm information reported during the initial assessment, and ask client about the need for additional services.

9. **Continued Eligibility**

   - May want to ask the client regarding what he/she does for other meals, i.e., meals not provided by the Nutrition Program. This may give insight into the continued need for HDM's.

Six Month Home Delivered Meal Contact

Non - Case Managed Home Delivered Meal Clients

The following information should be explored by the assessor during the six-month contact for non-case managed home delivered meal clients. Event based reassessments must be conducted within 5 days if there is a change in the client's situation which would affect the care plan.

Questions refer to **CHANGES** from the most recent prior assessment.

Contact Date: _____

I. Client Information

A. Name: _____

B. Has marital status changed ? Yes_____ No _____

___Married ___Widowed ___Divorced ___Separated ___Single

C. Has living arrangement changed ? Yes_____ No _____
Indicate current arrangement.

___Alone ___With Spouse ___With Relative(s) ___With non-relatives

D. Has emergency contact changed ? __ No ___ Yes (update contacts)

Primary

Name: _____

Address: _____

_____

Relationship: _____

Phone: _____

_____

Secondary

Name: _____

Address: _____

_____

Relationship: _____

Phone: _____

_____

The client information contained in this instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with the program requirements, including but not limited to, monitoring, research and evaluation.

II. Health Status

Date of last visit to primary medical provider _____

Reason for visit:_____

_____

Current status of chronic illnesses or disability ? Improved, remained the same,

or worsened ? Describe if changed :_____

_____

Has need for assistive device(s) changed ? ___ Yes ___ No
If yes, name each device and specify reason(s) for use. _____

_____

_____

_____

Any hospitalizations in past six months ? ___ Yes __ No
Date : _____ Reason: _____

_____

Any emergency room visit in past six months ? ___ Yes __ No

Reason: _____

Did emergency room visit result in admittance ? _____ Yes ____No

III. Nutrition

Does client believe meals are still needed ? ____ Yes ___ No
Reason(s) : _____

_____

Is the quality of meals satisfactory ? _____Yes _____No
Are portion sizes adequate ? _____ Yes _____ No
Is the variety of foods satisfactory ? ____ Yes ____ No
Comments: _____

_____

Permission form to Allow Assessor to Obtain Information

COUNTY OF SUFFOLK

Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

PERMISSION TO OBTAIN INFORMATION

IN THE EVENT THAT I REQUIRE A DIET MODIFICATION I CONSENT TO ALLOW THE HOME DELIVERED MEAL ASSESSOR TO CONTACT MY PHYSICIAN TO APPROVE THE MENU THAT IS USED.

I UNDERSTAND AND CONSENT TO THE ASSESSOR MAKING THE NECESSARY REFERRALS IN ORDER FOR ME TO RECEIVE ANY BENEFITS AND SERVICES FOR WHICH I AM ENTITLED.

SIGNATURE OF PARTICIPANT: _____

SIGNATURE OF ASSESSOR: _____

DATE: _____

H. LEE DENNISON BUILDING ♦ 100 VETERANS MEMORIAL HIGHWAY ♦ P.O. BOX 6100 ♦ HAUPPAUGE, N. Y. 11788-0099 ♦ (631) 853-8200
FAX 853-8225